

HOSPITAL BEDS STANDARD ADVISORY COMMITTEE (HBSAC) MEETING

Wednesday, September 1, 2004

Michigan Historical & Library Center
702 W. Kalamazoo Street
Lake Ontario Room
Lansing, MI 48915

APPROVED MINUTES

I. Call to Order.

Chairperson Dale Steiger called the meeting to order at 10:10 a.m.

a. Members Present and Organizations Represented:

Dale L. Steiger, Blue Cross Blue Shield of Michigan, Chairperson
Robert Asmussen, Ascension Health/St. John Health System
(arrived at 10:20 a.m. and left at 2:30 p.m.)
James F. Ball, Michigan Manufacturers Association
Brooks F. Bock, MD, Wayne State University (Alternate) (arrived at 10:30 a.m.)
Greg S. Dobis, McLaren Health Care
James B. Falahee, Jr., Bronson Healthcare Group
Maureen A. Halligan, Genesys Health System
Edmund Kemp, Michigan Department of Community Health (Alternate)
Carol Parker Lee, Michigan Primary Care Association
Sande MacLeod, UFCW 951
Robert Meeker, Alliance for Health
Patrick G. O'Donovan, Beaumont Hospitals
Anne Rosewarne, Michigan Health Council
Vinod K. Sahney, Henry Ford Health System (left at 2:35 p.m.)
Thomas Smith, Economic Alliance for Michigan
Kenneth G. Trester, Oakwood Healthcare, Inc.

b. Members Absent and Organizations Represented:

John D. Crissman, MD, Wayne State University, School of Medicine
Eric Fischer, The Detroit Medical Center
Stephen Fitton, Michigan Department of Community Health
Denise Holmes, Michigan State University, College of Human Medicine

c. **Staff Present:**

Lakshmi Amarnath
Jan Christensen
William Hart
Larry Horvath
John Hubinger
Joette Laseur
Andrea Moore
Stan Nash
Brenda Rogers

d. **General Public in Attendance:**

There were approximately 29 people in attendance.

II. Declarations of Conflicts of Interest.

None were noted.

III. Review of Agenda.

The agenda was adjusted to put item V A(i) and V A(ii) first and place item V B after item VII. Motion by Ms. MacLeod, seconded by Mr. O'Donovan, to accept the agenda as modified. Motion Carried.

IV. Review of Draft Minutes of August 10, 2004.

The Minutes were corrected as follows:

1. In Section VII (A) change to "Mr. Meeker provided an overview of the workgroup's progress on the requested maps and tasks."
2. In Section XII change Mr. MacLeod to Ms. MacLeod.

Motion by Mr. Ball, seconded by Mr. Trester, to accept the minutes as modified. Motion Carried.

V. Work Groups – Updates

A. Geography/Decision Rules.

Mr. Meeker provided an overview of the workgroups progress. (Attachment A)

Peg Reihmer, Botsford Hospital, addressed the Committee.

i. Schedule of Deliverables.

ii. Update on Travel Time Methodology.

Dr. Richard Groop and Dr. Joe Messina provided a presentation showing sample maps and the schedule for the delivery of the final maps. Discussion followed.

Lunch Break 12:20 p.m. – 1:12 p.m.

VI. Report to CON Commission at the September 14, 2004, Meeting.

Discussion regarding the Committee's charge.

Mr. Larry Horwitz, Economic Alliance, addressed the Committee.

Further discussion. Chairperson Steiger asked Dr. Sahney to write up his proposal regarding the subarea methodology and provide it to the Workgroup at its September 10, 2004 meeting.

Mr. Larry Horwitz, Economic Alliance, addressed the Committee.

VII. "High Occupancy" Hospitals.

Mr. Horvath presented an overview of the applications received and the outcome of each application. Mr. Nash gave an overview of the data calculations.

Motion by Mr. Falahee, seconded by Ms. Halligan, to move the High Occupancy language, which was a pilot program, to become a permanent program by striking the references in the standards that refer to pilot program (the initial phrase and Section 4), in principle, subject to any revisions presented to deal with potential issues raised.

Discussion followed.

Ms. Penny Crissman, Crittenton Hospital, addressed the Committee.

Ms. Amy Barkholz, MHA, addressed the Committee.

Mr. Mark Mailloux, University of Michigan Health System, addressed the Committee.

Discussion continued.

Motion by Mr. Bock to table this issue until draft language is presented to the Committee for review. Motion failed due to lack of support.

Motion by Mr. Falahee Carried.

VIII. Hospital Bed Inventory – Licensing Action.

Mr. Ball provided an overview. This issue will be referred back to the Commission.

IX. Review Proposed Addendum for Special Bed Allocations.

This issue was tabled pending the outcome of the Workgroup.

X. Survey of Other States – Report.

Mr. Horvath and Ms. Amarnath provided a report of the data that was collected for each state. (Attachment B) Discussion followed. An additional question was raised; what are the licensure requirements in CON and non-CON states for a minimum or maximum size hospital.

XI. Future Meeting Date – September 23, 2004 and October 12, 2004.

No changes made.

XII. Public Comment.

None received.

XIII. Adjournment.

Motion by Mr. Ball, seconded by Mr. Meeker, to adjourn the meeting at 3:07 p.m.
Motion Carried.

GEOGRAPHIC ACCESS TO HOSPITAL SERVICES

WORK GROUP RECOMMENDATIONS ON DECISION RULES AND IMPLEMENTATION PROCESS

ATTACHMENT A

Access-based Methodology to Determine the Need for New Hospitals

Purpose: Identify “pockets” of Michigan’s population, which have inadequate access to basic hospital services (measured by travel time), and which represent at least a minimum critical mass of demand for inpatient acute care.

1. **Decision Rules** to determine inadequate access to basic hospital services
 - a What are basic hospital services requiring community access?
 - i) Recommendation: 24-hr., short-stay acute care beds & 24 hr. emergency services
 - ii) Rationale: Inclusion of hospitals with 24-hour emergency services eliminates specialty hospitals, which should be excluded when examining access issues
 - b What is a maximum acceptable average travel time to a hospital?
 - i) Recommendation: 30 minutes
 - ii) Rationale: Included in planning guidelines cited in Institute of Medicine report from 1980, including standards for access to general hospitals, pediatric inpatient services, & obstetrical services. Also cited in hospital access article in *Medical Care*, 1976. Current guidelines for the Veterans Administration (2004) use 60 minutes for their recipients in urban areas and 90 minutes in rural areas.
2. **Implementation Steps** to translate decision rules to population-based hospital bed need for people who live outside the maximum travel time to a hospital
 - a Identify geographic areas outside 30-minute travel times using proximity analysis performed by MSU Department of Geography. Analysis will use 3 x 3 mile squares.
 - b Contiguous 3 x 3 mile squares which meet the criteria of a, above, are defined as “access deprived areas.”
 - c Determine the population of the access-deprived area by summing the age-specific populations (for both base year and planning year) for all the 3 x 3 mile squares in the access-deprived area.
 - d Aggregate the 3-mile squares into zip codes.
 - e For each zip-code partially or totally in the access-deprived area, calculate the base year age specific use identified in Sec. 4(1)(f) of the Standards by dividing the age specific patient days by its corresponding population.
 - f For each of the same zip codes, calculate the plan year age specific use rates by multiplying the age-specific zip code rates calculated in e, above, by the projected age-specific population of the zip code.
 - g For each zip-code or partial zip code area, calculate the projected patient days for each age group identified in Sec. 4(1)(f) of the Standards by multiplying the age-specific hospital use rates for the entire zip code in the base year times the projected planning year population of the portion of the zip code area within the access-deprived area.
 - h Sum the results of g, above, for all contiguous zip code and partial zip code areas within the access-deprived area to determine total patient days represented by the access-deprived area in the planning year.

- i Apply the acute care bed need methodology to results of v, above, beginning with Sec. 4(1)(j) of the Standards to determine hospital bed need represented by the access-deprived area in the planning year.
 - i) Convert total patient days to average daily census (ADC) from within the access-deprived area.
 - ii) Convert ADC to hospital bed need, using the occupancy tables already contained in the CON Standards.

3. **Additional decision rules** to determine if the need for hospital beds in the access-deprived area exceeds the minimum critical mass to justify a new hospital.

- a What should be the minimum size of a potential new hospital? The results of the need methodology described above must result in the need for at least a minimally sized hospital, in order for a potential new hospital to be viable in the access-deprived area.
 - i) Recommendation: 200 beds in metropolitan county
50 beds in rural or micropolitan county
 - ii) Rationale: These requirements are included in existing CON Review Standards. Note: There is significant belief within the Work Group that the hospital industry has changed significantly since these numbers were first developed. This is reinforced by anecdotal evidence from the Advisory Board that smaller hospitals are being built in metropolitan areas elsewhere in the country. Therefore, the Work Group will continue to research this question.
- b What basic hospital services should be available at a potential new hospital?
 - i) Recommendation: 24-hr., short-stay acute care beds, 24 hr. emergency services, obstetrics
 - ii) Rationale: Since this exception to the bed need standards identifies needed access to general community hospitals, the Work Group believes that it should not be opened to potential specialty hospitals. Requirements for obstetrics and 24-hour emergency services are characteristic of general community hospitals.
- c What should be the planning year?
 - i) Recommendation: 5 years in the future (measured from the "base year" as defined in the CON Standards).
 - ii) Rationale: Although this number is consistent with the existing CON standards, the Work Group agrees with the previous TAC that the planning horizon actually should be 10 years and urges the SAC to reconsider this question.
- d Where should a potential new hospital be located?
 - i) Recommendation: Within the area identified as access-deprived and, therefore, at least 30 minutes travel time from any existing hospital.
 - ii) Further Recommendation: for applicants applying under this provision, a comparative review criterion should be applied such that points are awarded to the applicant whose proposed location has the largest number of people from the access-deprived area within a 30-minute travel time.

4. **Other Considerations – Comparative Review**

In order for this approach to be applied, the SAC will need to develop a full set of comparative review criteria for the CON Review Standards for Hospital Beds.

Survey Questions	CT	VT	WV	NC	MS	RI	KY	IL
Do you have a minimum # of beds requirement for a new hospital?	No (Case by case basis)	No (Need requirement Case by case Basis 13 hosps-2 tertiary, others rural hosps)	No (54 acute care hosps)	No (need determination in the State Plan and financial feasibility)	No (based on the need)	No	No	Yes Hosp. to be located in a M.S.A must contain a minimum of 100 MS beds. Rural Hosp. located outside a M.S.A or located <=15 miles from a county outside M.S.A and is licensed to perform med/surg. or OB services and has a total bed capacity of <=75 beds in these 2 service categories. (M.S.A=Metropolitan Statistical Area)
If Yes, how many?								
Do you differentiate between Rural and Urban?								
If yes, what are the minimum sizes?								
What is the basis for your determination?								
If the existing hospital is going to replace itself for relocate, do you have a maximum distance to do it?	No (Case by case basis)	No (Case by case basis, need to go through the process)	15 miles within the regional facility or in the same county (Standards revised in 2002- Earlier within 5 mls difficulty in topography)	Within the same county	Preferably within the county	No (not in regulation)	No (based on the need- no other restrictions)	No (Prefer facility staying within the designated planned area-but it is not a requirement).
- Within the whole county?								
- Mileage distance or limitation?								
What is the basis?				Must meet Statutory Requirements	Based on the need, # of beds Cann't impinge on other facilities		Demonstrate the need for relocation	

Survey Questions	SC	AL	NH	MO	FL	DE	NJ	VA
Do you have a minimum # of beds requirement for a new hospital?	No (based on the need)	Yes Minimum # of beds=25 It is the same requirement for rural and urban hosps.	No The new facility cannot cause the total number of beds statewide to exceed a ratio of 3.1 beds for every 1000 persons living in NH.	No There is a minimum requirement for # of beds by service category e.g. Med/ Surg. OB	No Rural hospitals <=100 beds CAHs<=25 beds	No (A small State - They have one hospital per county)	Yes 200 beds for new hosps. (old hosps.exist with less than 200 beds)	No
If Yes, how many?								
Do you differentiate between Rural and Urban?								
If yes, what are the minimum sizes?								
What is the basis for your determination?								
If the existing hospital is going to replace itself for relocate, do you have a maximum distance to do it?	No	No Relocate within the same county Planning is based on county by county	No Demonstrate that increases in market share will not be detrimental to the occupancy rates in other hosps. in the service area.	No There are no special provisions. Treated like a new hosp.and they have to go through the entire CON process	Yes Within one mile - No CON review (must be in the same subdistrict area) >1 mile – CON review required	No (Never had such a situation)	No For any relocation, the facility has to go through the CON process.	No For any relocation, the facility has to go through the CON process.
- Within the whole county?								
- Mileage distance or limitation?								
What is the basis?								